

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
Fax Number:		Fax Number:

Trastuzumab deruxtecan

Initial application

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient is currently on treatment with trastuzumab deruxtecan and met all remaining criteria prior to commencing treatment
- or
- ☐ Patient has metastatic breast cancer expressing HER-2 IHC3+ or ISH+ (including FISH or other current technology)

and

☐ Patient has previously received trastuzumab and chemotherapy, separately or in combination

and

☐ The patient has received prior therapy for metastatic disease

or

☐ The patient developed disease recurrence during, or within six months of completing adjuvant therapy

and

☐ Patient has a good performance status (ECOG 0-1)

and

☐ Patient has not received prior funded trastuzumab deruxtecan treatment

and

☐ Treatment to be discontinued at disease progression

Renewal

Current approval Number (if known):.....

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab deruxtecan
- and
- ☐ Treatment to be discontinued at disease progression

Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz